FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 N. Pulaski Road (Number) Chicago (City) 60630 (Zip Code)

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

IDPA ID Number: 36-3980966

Date of Initial License for Current Owners: 11-May-95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773)604-8112

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 30-March-2001 (Date)

(Type or Print Name) Christopher Vicere

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N / A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	57,096	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,018	2,713	3,314	10,045	8
9	SNF/PED					9
10	ICF	38,145	4,286	28	42,459	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,163	6,999	3,342	52,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.96%

D. How many bed-hold days during this year were paid by Public Aid? 139 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11-May-1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11-May-1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 3,026

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	280,335	46,912	5,108	332,355		332,355		332,355			1
2	Food Purchase		305,836		305,836	(25,748)	280,088	(387)	279,701			2
3	Housekeeping	166,095	18,733	69,471	254,299		254,299		254,299			3
4	Laundry	34,478	1,639	199,432	235,549		235,549		235,549			4
5	Heat and Other Utilities			184,596	184,596		184,596		184,596			5
6	Maintenance	73,083	20,662	168,638	262,383		262,383	3,685	266,068			6
7	Other (specify):*											7
8	**TOTAL General Services**	553,991	393,782	627,245	1,575,018	(25,748)	1,549,270	3,298	1,552,568			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,929,395	113,024	130,042	2,172,461		2,172,461		2,172,461			10
10a	Therapy			25,193	25,193		25,193		25,193			10a
11	Activities	145,063	12,915	2,117	160,095		160,095		160,095			11
12	Social Services	68,380		2,198	70,578		70,578		70,578			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,142,838	125,939	162,550	2,431,327		2,431,327		2,431,327			16
	C. General Administration											
17	Administrative	68,737		84,000	152,737		152,737	(53,859)	98,878			17
18	Directors Fees											18
19	Professional Services			29,199	29,199		29,199	1,522	30,721			19
20	Dues, Fees, Subscriptions & Promotions			92,901	92,901		92,901	(59,205)	33,696			20
21	Clerical & General Office Expenses	195,367	78,417	98,069	371,853		371,853	28,018	399,871			21
22	Employee Benefits & Payroll Taxes			357,556	357,556	285	357,841	1,764	359,605			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,706	5,706		5,706	428	6,134			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,876	38,876		38,876		38,876			26
27	Other (specify):*							3,093	3,093			27
28	**TOTAL General Administration**	264,104	78,417	706,307	1,048,828	285	1,049,113	(78,239)	970,874			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,960,933	598,138	1,496,102	5,055,173	(25,463)	5,029,710	(74,941)	4,954,769			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairmont Care Centre #0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			285,777	285,777		285,777	160,490	446,267			30
31	Amortization of Pre-Op. & Org.			4,474	4,474		4,474		4,474			31
32	Interest			310,282	310,282		310,282	(291,098)	19,184			32
33	Real Estate Taxes			239,207	239,207		239,207		239,207			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(900,000)				34
35	Rent-Equipment & Vehicles			2,219	2,219		2,219		2,219			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,741,959	1,741,959		1,741,959	(1,030,608)	711,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,620	62,000	145,620		145,620		145,620			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,644	85,644		85,644		85,644			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		83,620	147,644	231,264		231,264		231,264			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,960,933	681,758	3,385,705	7,028,396	(25,463)	7,002,933	(1,105,549)	5,897,384			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	98,409	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(387)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(775)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(57,876)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,363)	20		28
29	Other-Attach Schedule **Deferred Maintenance Cost**	3,685	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 41,693		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,147,242)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,147,242)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,105,549)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost	$ 3,685	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
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46				46
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68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	3,685		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(387)	0	0	0	0	0	0	0	0	0	0	(387)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,685	0	0	0	0	0	0	0	0	0	0	3,685	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,298	0	0	0	0	0	0	0	0	0	0	3,298	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(53,859)	0	0	0	0	0	0	0	0	(53,859)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,522	0	0	0	0	0	0	0	0	1,522	19
20	Fees, Subscriptions & Promotions	(60,014)	0	809	0	0	0	0	0	0	0	0	(59,205)	20
21	Clerical & General Office Expenses	0	0	28,018	0	0	0	0	0	0	0	0	28,018	21
22	Employee Benefits & Payroll Taxes	0	0	1,764	0	0	0	0	0	0	0	0	1,764	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	428	0	0	0	0	0	0	0	0	428	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	3,093	0	0	0	0	0	0	0	0	3,093	27
28	**TOTAL General Administration**	(60,014)	0	(18,225)	0	0	0	0	0	0	0	0	(78,239)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,716)	0	(18,225)	0	0	0	0	0	0	0	0	(74,941)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	98,409	61,971	110	0	0	0	0	0	0	0	0	160,490	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	243,965	(535,063)	0	0	0	0	0	0	0	0	(291,098)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(900,000)	0	0	0	0	0	0	0	0	0	(900,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	98,409	(594,064)	(534,953)	0	0	0	0	0	0	0	0	(1,030,608)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	41,693	(594,064)	(553,178)	0	0	0	0	0	0	0	0	(1,105,549)	45

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental	$ 900,000	Fairmont Associates	100.00%	$	$ (900,000)	1
2	V	32	Interest	132,692	Fairmont Associates	100.00%	376,657	243,965	2
3	V	30	Depreciation		Fairmont Associates	100.00%	61,971	61,971	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,032,692			$ 438,628	$ * (594,064)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salary - Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 26,077	$ 26,077	15
16	V	27	P/R Taxes-Cynthia and Laurence		Lancaster, Ltd.	100.00%	728	728	16
17	V	17	Management Fee Income	84,000	Lancaster, Ltd.	100.00%		(84,000)	17
18	V	19	Professional Services		Lancaster, Ltd.	100.00%	1,522	1,522	18
19	V	21	Office Expenses		Lancaster, Ltd.	100.00%	1,750	1,750	19
20	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	1,764	1,764	20
21	V	24	Education & Seminars		Lancaster, Ltd.	100.00%	428	428	21
22	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	4,064	4,064	22
23	V	32	Interest	552,759	Lancaster, Ltd.	100.00%	17,696	(535,063)	23
24	V	30	Depreciation		Lancaster, Ltd.	100.00%	110	110	24
25	V	21	Salaries-Clerical		Lancaster, Ltd.	100.00%	26,268	26,268	25
26	V	27	P/R Taxes-Clerical		Lancaster, Ltd.	100.00%	2,365	2,365	26
27	V	20	Advertising		Lancaster, Ltd.	100.00%	809	809	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 636,759			$ 83,581	$ * (553,178)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	50.00%	See Attached	2	3.00%	Lancaster	$ 11,077	17-7	1
2	Laurence Zung	Officer	Administrative	50.00%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,077		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 3520 W. Thorndale Ave.
City / State / Zip Code: Chicago, IL 60659.
Phone Number: (773) 539-8181.
Fax Number: (773) 539-8133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 360,000	$ 360,000	2	$ 11,077	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054		2	309	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054		2	419	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361		84,000	1,522	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313		84,000	1,750	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548		84,000	1,764	9
10	24	Education & Seminars	Management Fees	1,455,000	7	7,408		84,000	428	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392		84,000	4,064	11
12	32	Interest	Management Fees	1,455,000	7	306,522		84,000	17,696	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898		84,000	110	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	84,000	26,268	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971		84,000	2,365	15
16	20	Advertising	Management Fees	1,455,000	7	14,009		84,000	809	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,723,528	$ 1,174,998		$ 83,581	25

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working Capital	Interest Only	5/11/95			Demand	Prime	1,159	6
7	Lancaster	X								Prime	176,431	7
8	Fairmont Associates	X									132,692	8
9	TOTAL Facility Related						$	$			$ 310,282	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 310,282	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	165,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	214,207	2
3. Under or (over) accrual (line 2 minus line 1).	$	49,207	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	190,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** 19 ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	239,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	195,802	8
	1996	120,126	9
	1997	159,194	10
	1998	162,020	11
	1999	178,617	12

** Based on 1999 actual Taxes, increased for inflation. **

** $35,590 of additional 1995 Tax assessed. **

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

*** NONE ***

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 67,109
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 4,474
4. Dates Incurred: 11-May-1995

Nature of Costs: Pre-Operating Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility	218,869	1995	$ 685,000	1
2					2
3	TOTALS	218,869		$ 685,000	3

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156		1995		$ 2,240,980	$ 57,370	20	$ 112,049	$ 54,679	$ 645,399	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Canopy and Awning			1995	3,300	85	20	165	80	935	9
10	Intercom System			1995	1,844	47	20	92	45	494	10
11	Roof Exhausters			1996	2,136	55	20	107	52	464	11
12	Permanent Signage			1997	16,625	1,330	15	1,663	333	5,266	12
13	Fire Alarm			1997	68,600	1,759	20	3,430	1,671	11,148	13
14	Parking Lot Excavation			1997	45,000	3,599	15	4,500	901	14,625	14
15	Parking Lot Asphalt			1997	68,000	5,439	15	3,400	(2,039)	11,050	15
16	Concrete Curbs			1997	18,000	1,440	15	900	(540)	2,925	16
17	Phase I Expansion-Landscaping			1997	41,000	3,279	15	2,050	(1,229)	6,663	17
18	Site Sewer			1997	28,500	2,280	15	1,425	(855)	4,631	18
19	Phase I Expansion-Building			1997	1,218,394	31,241	20	60,920	29,679	197,990	19
20	Ceramic Tiled Hallway			1998	10,603	272	15	530	258	1,413	20
21	Electrical Enhancements			1998	6,210	159	15	311	152	829	21
22	Phase II Landscape			1999	15,000	1,425	15	1,425		2,175	22
23	Site Sewer			1999	40,376	3,836	15	3,836		5,855	23
24	Fire Protection			1999	43,440	1,114	20	1,114		1,439	24
25	Excavation			1999	49,650	4,717	15	4,717		7,200	25
26	Phase II Expansion			1999	2,281,933	58,511	20	58,511		75,577	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,199,591	$ 177,958		$ 261,145	$ 83,187	$ 996,078	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,339,377	$ 161,324	$ 181,147	$ 19,823	10	$ 650,675	37
38	Current Year Purchases	19,874	3,975	3,975		10	3,975	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,359,251	$ 165,299	$ 185,122	$ 19,823		$ 654,650	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,243,842	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 343,257	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 446,267	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 103,010	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,650,728	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Rental Property	$ 179,744	$ 4,601	$ 25,877	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 179,744	$ 4,601	$ 25,877	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,219 Description: Minolta Copier $184.92/month
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 18,691	$		$ 18,691	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,009			6,009	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			37,300			37,300	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				65,329		65,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies Other (specify): Rental Speciality Beds	39-2 39-2					7,169 11,122		7,169 11,122	13
14	TOTAL			$		$ 62,000	$ 83,620		$ 145,620	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (168,842)	$ (167,888)	1
2	Cash-Patient Deposits	46,407	46,407	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,501,547	1,501,547	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,574	36,574	6
7	Other Prepaid Expenses	23,365	23,365	7
8	Accounts Receivable (owners or related parties)	125,459	125,459	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,564,510	$ 1,565,464	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	3,958,611	3,958,611	15
16	Equipment, at Historical Cost	1,359,252	1,359,252	16
17	Accumulated Depreciation (book methods)	(1,338,562)	(1,693,040)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,979,301	$ 6,730,547	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,543,811	$ 8,296,011	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,354	$ 310,354	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,407	46,407	28
29	Short-Term Notes Payable	3,715,416	5,458,250	29
30	Accrued Salaries Payable	236,230	236,230	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,163	7,163	31
32	Accrued Real Estate Taxes(Sch.IX-B)	190,000	190,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,505,570	$ 6,248,404	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,505,570	$ 6,248,404	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,038,571	$ 2,047,937	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,544,141	$ 8,296,341	48

***(See instructions.)**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 856,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 856,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	182,323	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 182,323	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,038,571	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		Total After Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,297,085	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,297,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	776,387	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(25,535)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 750,852	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,047,937	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,344,089	1
2	Discounts and Allowances for all Levels	(646,766)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,697,323	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,479	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 271,479	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	55,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,004	19
20	Radiology and X-Ray	1,383	20
21	Other Medical Services	93,640	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 157,144	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	369	28
28a	Rental Income	84,404	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 84,773	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,210,719	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,575,018	31
32	Health Care	2,431,327	32
33	General Administration	1,048,828	33
	B. Capital Expense		
34	Ownership	1,741,959	34
	C. Ancillary Expense		
35	Special Cost Centers	145,620	35
36	Provider Participation Fee	85,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,028,396	40
41	**Income before Income Taxes (line 30 minus line 40)****	182,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 182,323	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. Cash Basis Tax Payer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,826	2,030	$ 55,441	$ 27.31	1
2	Assistant Director of Nursing	3,752	4,429	103,142	23.29	2
3	Registered Nurses	33,891	37,088	773,893	20.87	3
4	Licensed Practical Nurses	283	287	4,867	16.96	4
5	Nurse Aides & Orderlies	105,755	112,161	950,499	8.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,990	2,076	34,777	16.75	9
10	Activity Assistants	11,418	12,341	110,286	8.94	10
11	Social Service Workers	5,391	5,770	68,380	11.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,326	32,912	280,335	8.52	15
16	Dishwashers					16
17	Maintenance Workers	6,270	6,892	73,083	10.60	17
18	Housekeepers	22,720	24,125	166,095	6.88	18
19	Laundry	4,207	4,550	34,478	7.58	19
20	Administrator	1,689	1,790	68,737	38.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,621	13,675	195,367	14.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,794	2,974	41,553	13.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	244,933	263,100	$ 2,960,933 *	$ 11.25	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 5,108	1-3	35
36	Medical Director	150	3,000	9-3	36
37	Medical Records Consultant	98	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	350	3,504	10-3	39
40	Physical Therapy Consultant	763	25,193	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,117	11-3	44
45	Social Service Consultant	46	2,198	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,562	$ 45,152		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,559	$ 122,506	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	4,559	$ 122,506		53

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Debbi Del Re - upto 4/2000	Administrator	N/A	19,305
Nancy Elwart - effective 4/2000	Administrator	N/A	49,432
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,737

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 84,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 84,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 13,329
Personnel Planners, Inc.	Payroll Tax Consultant	505
Winston & Strawn	Legal	10,069
Richard Peelo & Associates	Accounting	2,500
Frost Ruttenberg & Rothblatt	Accounting	1,155
Panarese & Panarese	Legal	559
Sandra L. Thiel	Legal	395
Patricia K. Hogan	Legal	687
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,199

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,743
Unemployment Compensation Insurance	19,400
FICA Taxes	219,191
Employee Health Insurance	71,890
Employee Meals	25,748
Illinois Municipal Retirement Fund (IMRF)*	
*** Miscellaneous Employee Benefits ***	9,346
*** Uniform Allowance ***	2,986
*** Retirement Plan Contribution ***	14,000
*** Lancaster Allocation ***	1,764
TOTAL (agree to Schedule V, line 22, col.8)	$ 385,068

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
** N/A **		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	26,215
Health Care Worker Background Check	
(Indicate # of checks performed 43)	516
*** Licenses and Fees ***	6,096
*** Promotional Advertising ***	58,430
*** Dues and Subscriptions ***	469
*** Charitable Contributions ***	775
*** Lancaster Allocation ***	809
Less: Public Relations Expense	(775)
Non-allowable advertising	(57,876)
Yellow page advertising	(1,363)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,696

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,487
Seminar Expense	4,219
*** Lancaster Allocation***	428
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,134

**See instructions.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	Mar-97	$ 6,314	3	$ 1,052	$ 2,105	$ 2,105	$ 1,052	$	$	$	$	$
2	Painting and Decorating	Jun-97	11,071	3	1,845	3,690	3,690	1,846					
3	Painting and Decorating	Aug-97	6,553	3	1,092	2,184	2,184	1,093					
4	Painting and Decorating	Dec-97	12,824	3	2,137	4,275	4,275	2,137					
5	Painting and Decorating	Jan-98	9,551	3		1,592	3,184	3,184	1,592				
6	Painting and Decorating	Feb-98	3,620	3		603	1,207	1,207	603				
7	Painting and Decorating	Mar-98	3,141	3		523	1,047	1,047	523				
8	Painting and Decorating	Apr-98	7,306	3		1,218	2,435	2,435	1,218				
9	Painting and Decorating	Jul-98	1,009	3		168	336	336	168				
10	Painting and Decorating	Jul-99	26,214	3			4,369	8,738	8,738	4,369			
11	Painting and Decorating	Dec-99	13,669	3			2,278	4,556	4,556	2,279			
12	Painting and Decorating	Jan-00	4,221	3				703	1,407	1,407	704		
13	Painting and Decorating	Feb-00	10,169	3				1,694	3,390	3,390	1,695		
14	Painting and Decorating	Mar-00	606	3				101	202	202	101		
15	Painting and Decorating	Apr-00	2,192	3				365	730	730	366		
16	Painting and Decorating	Jul-00	241	3				40	80	80	41		
17	Painting and Decorating	Aug-00	592	3				98	198	198	98		
18	Painting and Decorating	Sep-00	2,588	3				431	863	863	431		
19	Painting and Decorating	Oct-00	8,123	3				1,354	2,707	2,707	1,355		
20	TOTALS		$ 130,004		$ 6,126	$ 16,358	$ 27,110	$ 32,417	$ 26,975	$ 16,225	$ 4,791	$	$

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,644**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,748** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.